CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: February 27, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Spinal cord stimulator trial between 1/11/2013 and 3/18/2013

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The physician is Board Certified in Physical Medicine and Rehabilitation with over 16 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
06/02/07: Daily Note from Spine and Rehab
06/11/07: Daily Note from Spine and Rehab
06/12/07: Daily Note from Spine and Rehab
06/15/07: MRI Lumbar Spine interpreted by MD

07/03/07: Office Visit by MD
08/02/07: MRI Cervical Spine interpreted by , MD
08/14/07: Behavioral Health Assessment by, MA, LPC
08/22/07: Lower EMG and NCV interpreted by, MD
12/12/07: Daily Note from Spine and Rehab
12/19/07: Daily Note from Spine and Rehab
01/15/08: Office Visit by, MD
01/29/08: Daily Note from Spine and Rehab
02/06/08: EMG/NCV of the Upper Extremities interpreted by, MD
04/01/08: Office Visit by, MD
05/07/08: Lumbar Myelogram and Postmyelogram CT interpreted by MD
05/13/08: Office Visit by, MD
12/08/08: Initial Office Visit/Second Opinion by MD
01/12/09: UR regarding CT scan, post discogram, lumbar spine.
01/23/09: Follow-up Office Visit by MD
02/26/09: Daily Note from Spine and Rehab
03/05/09: UR regarding Repeat Bilateral Lower Extremity EMG/NCV
04/14/09: UR regarding Repeat Bilateral Lower Extremity EMG/NCV
04/21/09: Office Visit by MD
05/08/09: Notice of Independent Review Decision regarding Repeat Bilateral Lower Extremity EMG/NCV
05/20/09: Lumbar Myelogram interpreted by MD
05/20/09: Postmyelogram CT of the Lumbar Spine, interpreted by MD
05/26/09: Office Visit by MD
06/11/09: Daily Note from Spine and Rehab
07/24/09: Designated Doctor Evaluation by MD
08/10/09: Subsequent Evaluation at Spine and Rehab
08/12/09: Follow-up Note by MD with PA
09/04/09: UR regarding Lumbar ESI @ L4-L5/L5-S1
09/09/09: Follow-up Note by MD
09/18/09: Reconsideration for Chiropractic Manipulation by DC
09/29/09: UR regarding Lumbar ESI @ L4-L/L5-S1
11/25/09: Notice of Independent Review Decision regarding Lumbar ESI @ L4-L5/L5-S1
12/01/09: Subsequent Evaluation by, MD
12/16/09: Follow-up Note by MD
05/25/10: Office Visit by MD
07/13/10: Notice of Independent Review Decision regarding Lumbar Spinal Surgery
08/25/10: Operative Report by MD
11/09/10: Office Visit by MD
12/07/10: Office Visit by MD
01/17/11: Follow-up Note by MD
01/27/11: Subsequent Evaluation by DC
02/08/11: Office Visit by MD
02/25/11: Operative Report by MD
04/11/11: Subsequent Evaluation by DC

06/06/11: IRO Request for Physical Therapy by DC
06/22/11: CT Cervical Spine
06/28/11: Notice of Independent Review Decision regarding additional postop physical therapy
10/30/12: Follow-up Note by MD
11/30/12: Follow-up Note by MD
12/11/12: Psychological Evaluation by LCSW and PhD
01/14/13: Follow-up Note by MD
01/16/13: UR performed by MD
01/24/13: UR performed by MD

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who was injured on xx/xx/xx after she slipped, but caught herself, injuring her low back. Her surgical history is positive for previous lumbar spine surgery by Dr. in 2002 to include L4-L5 and L5-S1 microsurgical techniques. She initially sought medical treatment at Medical Group. She then sought care under the direction of, DC and began a course of chiropractic therapy. In July of 2007 she was evaluated by MD

On June 15, 2007, MRI of the Lumbar Spine, Impression: 1. Intraosseous disc herniations at the L1-L2 and L2-L3 levels are seen. 2. At L4-L5 severe degenerative disc disease is noted with segmental instability. An annular bulge is present with bilateral facet joint arthrosis and severe narrowing of the right with moderate narrowing of the left neuroforamen. 3. At L5-S1 a 3.0 mm right subarticular and foraminal disc herniation is present flattening the thecal sac with moderate facet joint arthrosis and moderate bilateral foraminal narrowing.

On July 3, 2007, the claimant was evaluated by MD for neck pain and radiation to her right upper extremity with numbness and tingling, lower back pain, and right leg pain. X-rays of her pelvis revealed hips without degenerative joint disease and sacroiliac joints without sclerosis. X-rays of the lumbar spine to include flexion-extension views revealed L4-L5 and L5-S1 bone-on-bone spondylosis and stenosis with facet subluxation, foraminal stenosis, and mild scoliosis on AP view. X-rays of her cervical spine to include flexion-extension views reveal spondylolisthesis at C4-C5 measuring 2.5 mm and spondylolisthesis at C5-C6 measuring 3.5 mm in extension, which corrects in forward flexion. On physical examination of her back and lower extremities she had positive spring test at L4-L5 and L5-S1, positive Fortin finger test on the right, positive sciatic notch tenderness bilaterally, although worse on the right than on the left. Positive flip test bilaterally, positive Lasegue's on the right at 45 degrees contralateral, and positive straight leg raise on the left at 75 degrees with pain referred to back and right lower extremity, decreased knee jerk and ankle jerk on the right, absent posterior tibial tendon jerk bilaterally, paresthesias in the L5 and S1 nerve root distribution on the right, and weakness of gastrocsoleus on the right.
Assessment: 1. Failed lumbar spine syndrome with a recurrent herniated nucleus pulposus at L4-L5 and L5-S1 with failure of conservative treatment over 2 months. 2. Cervical loss of motion segment integrity with upper extremity radiculopathy,

probable herniated nucleus pulposus. Plan: Possible surgical intervention for both the lumbar and cervical spine.

On August 22, 2007, EMG/NCV of the lower extremity performed by MD. Impression: 1. There is an indication of acute irritability in the bilateral L4 and L5 motor roots with some chronic neuropathic changes in the S1 distributions bilaterally. 2. There is mild involvement of the lower sacral S2-S4 consistent with her urinary dysfunction following this date of injury.

On May 7, 2008, Lumbar Myelogram, Impression: Spondylitic changes L4-L5 without evidence of acute soft disc protrusion or high-grade canal or foraminal stenosis. Postmyelogram CT Lumbar Spine, Impression: Spondylitic change L4-L5 with broad-based disc bulging and prominent endplate sclerosis and reactive change. Anterior calcification of the capsule of the right L4-L5 facet joint with associated mild narrowing of the right L4-L5 neural foramen.

On May 20, 2009, Lumbar Myelogram, Impression: 1. Degenerative disc disease at L4-L5. There is a small anterior extradural impression on the thecal sac at L4-L5 suggesting slight bulging of the disc and degenerative spondylosis. No moderate or severe spinal stenosis is present. 2. Degenerative disc disease at L5-S1. No significant extradural defects on the thecal sac are present at L5-S1 on this myelogram.

On May 20, 2009, Postmyelogram CT Lumbar Spine, Impression: 1. Status post L4-L5 disc surgery with marked vertical disc space narrowing and discogenic endplate changes at L4-L5. Broad-based annular disc bulge with moderate bilateral foraminal stenosis and compression both L4 nerve roots. 2. At L5-S1 there is left paracentral disc herniation that abuts both S1 nerve roots in the lateral recess and displaces the left S1 nerve root posteriorly.

On December 16, 2009, the claimant was re-evaluated by MD for continued back pain listed as 7/10. It was reported that she had seen several spine surgeons without any success for getting her surgical lumbar spine surgery approved. It was also reported she recently had a fall with subsequent MRI scan done and ordered by Dr. Dr. noted that the claimant was demanding orthopedic beds, orthopedic braces and orthopedic lifts, for which he informed her he could not prescribe for. Current Medications were listed as Tylenol No. 3 and Soma prescribed by Dr. Assessment: 1. Chronic pain syndrome. 2. Low back pain. 3. Lumbosacral radiculitis. 4. Lumbar spondylosis. 5. Herniated nucleus pulposus. Plan: The patient has continued to deteriorate with continued degenerative spondylosis, chronic spinal symptoms, herniated disc and history of frequent falls. At this point in time, I will set her up for a psychological evaluation with Dr. office and pending no contraindications we will put in a request for trial neuromodulation, specifically a spinal cord stimulator placement for controlling her chronic pain symptoms and radicular pain.

On May 25, 2010, the claimant was reevaluated by MD for back pain and right leg pain that was unremitting. She entered the office with a cane in her right hand and had an antalgic gait. She also reported trouble with urinary incontinence. X-rays of her pelvis revealed hips without degenerative joint disease and sacroiliac joints without sclerosis. X-rays of the lumbar spine to include flexion-extension views reveal l4-L5 and L5-S1 laminotomy with complete collapse at L4-L5 and L5-S1 with facet subluxation, foraminal stenosis, bone-on-bone anterior column lack of support, and pinhole foraminal stenosis. On examination of her lower back she had positive spring test L4-L5 and L5-S1, positive extensor lag, and positive sciatic notch tenderness bilaterally although worse on the right than on the left. She had bilateral leg pain. She demonstrated a positive flip test bilaterally, positive Lasegue's bilaterally at 45 degrees, positive Bragard's bilaterally, absent posterior tibial tendon jerks bilaterally, hypoactive knee jerks bilaterally, hypoactive ankle jerks bilaterally, paresthesias in the L5 and S1 nerve root distribution on the right, weakness of gastroc-soleus on the right and on the left, and positive extensor lag. Plan: Revision lumbar spine surgery with total laminectomy L4-L5 and L5-S1, total facetectomy at L4-L5 and L5-S1, reduction of subluxation at L4-L5 and L5-S1 with global instrumented arthrodesis, and implantable bone growth stimulator as this is a 2 level procedure.

On August 25, 2010, Operative Report, Postoperative Diagnosis: Failed lumbar spine with recurrent HNP subluxation and instability L4-L5 and L5-S1. Adherent scar tissue to dura L5 nerve root on the left with stenosis L3-L4, stenosis first sacral interval, and abnormal examination under anesthesia and pain study. Procedure: Examination under anesthesia and pain study. Revision lumbar spine surgery with total laminectomy L5, total facetectomy, L5-S1. Decompression of the cauda equine, exposure of the L5-S1 disk space with discectomy, L5-S1 bilaterally. Additional interspace decompression, L3-L4 bilaterally with decompression of the cauda equine and neural foraminotomy of both L3 nerve roots. Revision sacral spine surgery first sacral interval bilaterally with excision of scar tissue laminectomy. Decompression of the cauda equine and neural foraminotomy of both S1 nerve roots. Microdissection technique, harvesting, and preparation of bone graft; intraoperative diskogram, L5-S1 positive; intraoperative diskogram, L4-L5 positive. Reduction of subluxation, L5-S1; reduction of subluxation L4-L5; Anterior arthrodesis, L5-S1; anterior arthrodesis, L4-L5; lateral arthrodesis L5-S1; lateral arthrodesis L4-L5. Cage placement, L5-S1 bilaterally; cage placement L4-L5 on the right, posterior instrumentation segmental fixation, L4 bilaterally, L5 bilaterally, S1 bilaterally with use of compression technique L4-L5 and L5-S1 bilaterally, use of crosslink L4-L5 and L5-S1 bilaterally, use of invasive electrical stimulation, implantation of EBI bone growth stimulator unit.

On December 7, 2010, the claimant was re-evaluated by MD who reported she had an exacerbation of back pain when she slipped at home and fell. She was worried about some change in position of the bone growth stimulator unit. She did not complain of leg pain. It was recommended she continue with conservative treatment.

On January 17, 2011, the claimant was reevaluated by MD for postlaminectomy syndrome with fusion and bone growth stimulator with a pain score of 10/10. Dr. requested bilateral L3-L4, L4-L5 and L5-S1 medial branch blockade under fluoroscopic control in attempt to decrease the claimant's lumbar pain. The claimant was reported to complain mostly of axial, non-radicular pain over the lumbar area. Clinically the pain seemed to originate on the facet joints. There was tenderness upon palpation of the area as well as exacerbation of the pain upon hyperextension and rotation of the lumbar area that radiated to the hips, the inguinal areas and to the anterior aspect of the thighs without going beyond the knees.

On February 25, 2011, Operative Report, Postoperative Diagnosis: Failed lumbar spine syndrome with retained symptomatic nonfunctioning bone growth stimulator for removal with normal examination under anesthesia and pain study, stable pedicle screws, crosslinks and rods L4-L5 and L5-S1 and first sacral interval. Procedures: Examination under anesthesia and pain study; revision lumbar spine surgery, L4-L5 bilaterally; additional interspace revision, L5-S1 bilaterally; revision sacral spine surgery first sacral interval bilaterally; microdiscection technique; removal of EBI transmitter unit; removal of EBI electrode units bilaterally; exploration of arthrodesis.

On October 30, 2012, the claimant was reevaluated by MD for continued pain level of 10/10. On physical examination she was positive for gluteal tenderness, tenderness of the greater trochanteric, paravertebral muscle spasm, SI joint tenderness, tenderness in the midline, decreased ROM. There was diminished strength and tone due to pain. Reflexes: Right patellar, 2 out of 4; Achilles tendon, 2 out of 4; Left patellar, 2 out of 4; Achilles tendon, 2 out of 4. Sensation to light touch and pinprick was intact. Plan: Prescribed Diazepam, Lidoderm, and Methadone. Referred for psychological clearance for SCS trial and therapy.

On November 30, 2012, the claimant was reevaluated by MD for questions regarding SCS trial. Dr. opined that the claimant had failed to respond to conservative treatment in the form of physical therapy, rehabilitation, medication, and injection therapy. Her pain level was severe and the she required high doses of narcotics in order to make the pain tolerable and allow her to function at a minimal level. She had undergone surgical treatment and had failed to obtain significant relief. At this point, he recommended a Spinal Cord Stimulator trial.

On December 11, 2012, the claimant underwent a psychological evaluation in which it was opined that she demonstrates no obvious mental condition that would prevent her from making decisions on her own. There was no evidence seen that she would not be a good candidate for use of a spinal cord stimulator.

On January 14, 2013, the claimant was reevaluated by MD for continued pain rated 10/10. It was also reported that she had been having bowl and incontinence problems since her date of injury. The pain was described as aching, burning, sharp, shooting over the lower back and was described as constant. Pain is

triggered when standing, while walking, with exercise, with any activity. Improves with lying down, with pain medication, worsens “suddenly” while walking, with activity and with standing. Dr. continued to recommend a SCS trial.

On January 16, 2013, MD performed a UR. Rationale for Denial: After careful review of the patient’s clinical presentation and medical history, and evidence based treatment guidelines, it appears that the patient is not a candidate for the requested spinal cord stimulator trial. Guidelines indicate that stimulator placement is appropriate in cases of failed back syndrome when the patient has undergone at least one previous surgery, and is not a candidate for repeat surgery, only if symptoms are primarily lower extremity radicular pain. While it is noted that the patient had undergone lumbar spine surgery without significant improvement, a review of available documentation failed to reveal symptoms of lower extremity radicular pain or objective findings suggestive of radiculopathy. Without symptoms of lower extremity radicular pain, stimulator placement would be incongruent with guideline recommendations. Based on the above discussion, the request for one spinal cord stimulator trial is recommended non-certified.

On January 24, 2013, MD performed a UR. Rationale for Denial: The prior determination is upheld at this time. It does not appear that the patient is a candidate for a spinal cord stimulator trial. As stated above, SCS indicated for cases involving failed back syndrome when the patient has undergone at least one previous surgery, and is not a candidate for repeat surgery, in addition to a history of failed back surgery, the ODG also requires that patients present with primarily lower extremity radicular pain and where there has been limited response to non-interventional care. As stated in review #349470, the patient does have a history of undergoing lumbar surgery, and she is not a candidate for additional surgery. However, the guidelines also require the patient’s symptoms to include primarily lower extremity radicular pain. As Dr. pointed out, there are no indications, in the most recent progress reports from 12/3/2012 and 11/1/2012 that describe subjective or objective signs of lower extremity radicular pain. Without documented presence of radicular signs or symptoms, the patient would not meet first indication for an SCS trial as outlined in the ODG.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Denial of the spinal cord stimulator trail is upheld/agreed upon. ODG Pain Chapter criteria is not met since submitted clinical information does not demonstrate symptoms or signs of lower extremity radicular pain. Therefore, the request for Spinal cord stimulator trial between 1/11/2013 and 3/18/2013 is not found to be medically necessary.

Per ODG:

Spinal cord stimulators (SCS)	Recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated, for specific conditions indicated below, and following a successful temporary trial. Although there is limited evidence in favor of Spinal Cord Stimulators (SCS) for Failed Back Surgery Syndrome (FBSS) and Complex Regional Pain Syndrome (CRPS) Type I, more trials are needed to confirm whether SCS is an effective treatment for certain types of chronic pain. (Mailis-Gagnon-Cochrane, 2004) (BlueCross BlueShield, 2004) See indications list below. See Complete list of SCS_References. This supporting evidence is significantly supplemented and enhanced when combined with the individually based observational evidence gained through an individual trial prior to implant. This individually based observational evidence should be used to demonstrate effectiveness and to determine appropriate subsequent treatment. (Sundaraj, 2005) Spinal Cord Stimulation is a treatment that has been used for more than 30 years, but only in the past five years has it met with widespread acceptance and recognition by the medical community. In the first decade after its introduction, SCS was extensively practiced and applied to a wide spectrum of pain diagnoses, probably indiscriminately. The results at follow-up were poor and the method soon fell in disrepute. In the last decade there has been growing awareness that SCS is a reasonably effective therapy for many patients suffering from neuropathic pain for which there is no alternative therapy. There are several reasons for this development, the principal one being that the indications have been more clearly identified. The enhanced design of electrodes, leads, and receivers/stimulators has substantially decreased the incidence of re-operations for device failure. Further, the introduction of the percutaneous electrode implantation has enabled trial stimulation, which is now commonly recognized as an indispensable step in assessing whether the treatment is appropriate for individual patients. (Furlan-Cochrane, 2004) These implantable devices have a very high initial cost relative to conventional medical management (CMM); however, over the lifetime of the carefully selected patient, SCS may lead to cost-saving and more health gain relative to CMM for FBSS and CRPS. (Taylor, 2005) (Taylor, 2006) SCS for treatment of chronic nonmalignant pain, including FBSS, has demonstrated a 74% long-term success rate (Kumar, 2006). SCS for treatment of failed back surgery syndrome (FBSS) reported better effectiveness compared to reoperation (North, 2005). A cost utility analysis of SCS versus reoperation for FBSS based on this RCT concluded that SCS was less expensive and more effective than reoperation, and should be the initial therapy of choice. Should SCS fail, reoperation is unlikely to succeed. (North, 2007) CRPS patients implanted with SCS reported pain relief of at least 50% over a median follow-up period of 33 months. (Taylor, 2006) SCS appears to be an effective therapy in the management of patients with CRPS. (Kemler, 2004) (Kemler, 2000) Recently published 5-year data from this study showed that change in pain intensity was not significantly different between the SCS plus PT group and the PT alone group, but in the subgroup analysis of implanted SCS patients, the change in pain intensity between the two groups approached statistical significance in favor of SCS, and 95% of patients with an implant would repeat the treatment for the same result. A thorough understanding of these results including the merits of intention-to-treat and as-treated forms of analysis as they relate to this therapy (where trial stimulation may result in a large drop-out rate) should be undertaken prior to definitive conclusions being made. (Kemler, 2008) Permanent pain relief in CRPS-I can be attained under long-term SCS therapy combined with physical therapy. (Harke, 2005) Neuromodulation may be successfully applied in the treatment of visceral pain, a common form of pain when internal organs are damaged or injured, if more traditional analgesic treatments have been unsuccessful. (Kapural, 2006) (Prager, 2007) A recent RCT of 100 failed back surgery syndrome (FBSS) patients randomized to receive spinal cord stimulation plus conventional

medical management (SCS group) or conventional medical management alone (CMM group), found that 48% of SCS patients versus 9% of CMM patients achieved the primary outcome of 50% or more pain relief at 6 months. This study, funded by Medtronic, suggested that FBSS patients randomized to spinal cord stimulation had 9 times the odds of achieving the primary end point. (Kumar, 2007) According to the European Federation of Neurological Societies (EFNS), spinal cord stimulation (SCS) is efficacious in failed back surgery syndrome (FBSS) and complex regional pain syndrome (CRPS) type I (level B recommendation). (Cruccu, 2007) The National Institute for Health and Clinical Excellence (NICE) of the UK just completed their Final Appraisal Determination (FAD) of the medical evidence on spinal cord stimulation (SCS), concluding that SCS is recommended as a treatment option for adults with chronic neuropathic pain lasting at least 6 months despite appropriate conventional medical management, and who have had a successful trial of stimulation. Recommended conditions include failed back surgery syndrome (FBSS) and complex regional pain syndrome (CRPS). (NICE, 2008) See also Psychological evaluations (SCS) in the Stress & Other Mental Conditions Chapter.

Battery Life for SCS: As batteries for both rechargeable and nonrechargeable systems are nearing end of life, there are both early replacement indicators and end of service notifications. Typcal life may be 8-9 years for rechargable batteries, but this depends on the unit. In addition, the physician programmer can be used to interrogate the implanted device and determine the estimated remaining battery life. (Restore, 2011)

Recent research: New 24-month data is available from a study randomizing 100 failed back surgery syndrome patients to receive spinal cord stimulation (SCS) plus conventional medical management (CMM) or CMM alone. At 24 months, the primary outcome was achieved by 37% randomized to SCS versus 2% to conventional medical management (CMM), and by 47% of patients who received SCS as final treatment versus 7% for CMM. All 100 patients in the study had undergone at least one previous anatomically successful spine surgery for a herniated disk but continued to experience moderate to severe pain in one or both legs, and to a lesser degree in the back, at least six months later. Conventional medical therapies included oral medications, nerve blocks, steroid injections, physical and psychological therapy and/or chiropractic care. (Kumar, 2008) (Frey, 2009) A nonrandomized, prospective cohort study in workers comp patients with chronic back and leg pain after spine surgery, ie failed back surgery syndrome (FBSS), found no significant difference in pain, disability, or opioid use between patients that received (at least a trial of) SCS, care at a pain clinic, or neither (usual care) at 12 and 24 months. Only 25% of SCS patients in this study received psychological screening prior to the trial, whereas ODG recommends psychological screening prior to all SCS implantations. Because few patients in any group in this study achieved success at any follow-up, the authors suggested that no treatment has a substantial impact on average in this patient group. (Turner, 2010)

Indications for stimulator implantation:

- • Failed back syndrome (persistent pain in patients who have undergone at least one previous back operation and are not candidates for repeat surgery), when all of the following are present: (1) symptoms are primarily lower extremity radicular pain; there has been limited response to non-interventional care (e.g. neuroleptic agents, analgesics, injections, physical therapy, etc.); (2) psychological clearance indicates realistic expectations and clearance for the procedure; (3) there is no current evidence of substance abuse issues; (4) there are no contraindications to a trial; (5) Permanent placement requires evidence of 50% pain relief and medication reduction or functional improvement after temporary trial. Estimates are in the range of 40-60% success rate 5 years after surgery. Neurostimulation is generally considered to be ineffective in treating nociceptive pain. The procedure should be employed with more caution in the cervical region than in the thoracic or lumbar due to potential complications and limited literature evidence.

	• • Complex Regional Pain Syndrome (CRPS)/Reflex sympathetic dystrophy (RSD), 70-90% success rate, at 14 to 41 months after surgery. (Note: This is a controversial diagnosis.) • • Post amputation pain (phantom limb pain), 68% success rate (Deer, 2001) • • Post herpetic neuralgia, 90% success rate (Deer, 2001) • • Spinal cord injury dysesthesias (pain in lower extremities associated with spinal cord injury) • • Pain associated with multiple sclerosis • • Peripheral vascular disease (insufficient blood flow to the lower extremity, causing pain and placing it at risk for amputation), 80% success at avoiding the need for amputation when the initial implant trial was successful. The data is also very strong for angina. (Flotte, 2004) For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**